Arkansas State Board of Nursing
1123 South University, Suite 800, Little Rock, AR 72204-1619 **Telephone 501-686-2700 Fax 501-686-2714**

Medication Report

INSTRUCTIONS:

Licensee: Fill in your name, your phone number and then check the correct box below. Ask your prescribing practitioner to complete the remainder of the form and request that they mail the form to the Board.

Practitioner providing medical treatment to Licensee: Please take a few moments to complete the form below. After completing the form, please mail to the Board at the above address. The completed form **must** be mailed by the practitioner. If you have any questions, please contact:

Licensee ______________________________Phone _____________**or** Director of Nursing Practice ____**Phyllis DeClerk**____Phone **501-686-2700**

Date	Method Given (Check all that apply)	Medication	Dosage, Route, Frequency	# Given	Reason for Medication	Expected Length of TX	Detox Plan (If necessary)
	☐ Administered in Office ☐ Sample(s) Given ☐ Prescription Given ☐ Prescription called to Pharmacy			# given ____ # Refills ____			
	☐ Administered in Office ☐ Sample(s) Given ☐ Prescription Given ☐ Prescription called to Pharmacy			# given ____ # Refills ____			
	☐ Administered in Office ☐ Sample(s) Given ☐ Prescription Given ☐ Prescription called to Pharmacy			# given ____ # Refills ____			
	☐ Administered in Office ☐ Sample(s) Given ☐ Prescription Given ☐ Prescription called to Pharmacy			# given ____ # Refills ____			

I understand that this patient should not consume ethanol or other abuse potential substances unless no reasonable medical alternative is available, because patient is:

☐ Recovering from chemical dependency and mood-altering drugs may trigger a relapse; or
☐ Being monitored for disciplinary compliance and has agreed to refrain from all abuse potential substances.

______________________ ______________________ ______________________ ______________________
Practitioner Signature | Practitioner Name (Please print) | Office Phone Number | Date